Peninsula Health

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Premier's Award Metropolitan Health Service of the Year 2007, 2009

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31 December 2013

Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Coroner Spanos

Findings without inquest in the matter of the death of Mr Paul Larman
Coroner's Reference: COR 2007 004142

We refer to the findings without an inquest in relation to the death of Paul Larman, delivered on 10 September 2013.

The following recommendations were made pursuant to section 72(2) of the *Coroners Act 2008* (Vic):

Recommendation 1:

In order to improve the safety of patients and their continuity of access to Clozapine, I recommend that SHMHS and PHMHS review their existing policies and procedures related to Clozapine to address what is required in relation to patients' own supplies of medications at the point of transfer, and the change from one brand of Clozapine to another.

Recommendation 2:

In order to improve the safety of all patients, I recommend that Peninsula Health includes information on the restrictions of Clozapine prescribing in the training and/or orientation of all medical officers, to decrease the risk of inappropriate and unsafe patient access to Clozapine.

Recommendation 3:

In order to improve the safety of patients who are prescribed Clozapine, I recommend that PHMHS reviews its guideline to increase frequency of review of such patients in the initial weeks following transfer from another mental health service on the basis that this is a recognised high-risk period.

We provide the following response to the recommendations.

Response to Recommendation 1:

In response to this recommendation, Peninsula Health has reviewed its Clozapine (Clopine) Clinical Practice Guideline. Pursuant to this review, the following additional guidelines have been included in the Clozapine (Clopine) Clinical Practice Guideline:

- *Clients will be referred for community follow up via triage in the usual way and will be contacted by the community team within 72 hours to arrange an appointment; frequency of contact will be planned with consideration of the increased risk a client may present during the period of transition*
- *In most situations the Clozapine Coordinator will be notified of the transfer by the referring Clozapine Centre however the receiving team is to liaise with the Coordinator to confirm this has happened*
- *Clozapine Coordinator to contact the referring centre to identify the date of and amount of medication from last prescription and the date of the next pathology and required medical view with the referring Clozapine Centre and confirm same with the receiving team*

NB: Clients transferring from other regions may have been managed on CLOZARIL; in that case the referral should be accompanied by a form transferring from CLOZARIL TO CLOPINE. Should this not be the case please liaise with the referring centre to receive same. As a reference please review the Clopine Connect Protocol (page 25), a copy of which is given to each prescribing medical staff member as well as available in each team and liaise with the Clozapine Coordinator for appropriate transition to CLOPINE. The Clozapine Coordinator will coordinate registration of the client with CLOPINE CONNECT.

The amended Clozapine (Clopine) Clinical Practice Guideline is **enclosed** for the Court's reference (**Enclosure A**).

The above amendments were made by the Mental Health team under the guidance of Associate Professor Sean Jespersen, Clinical Director, Peninsula Health Mental Health Service.

Response to Recommendation 2:

In response to this recommendation, Peninsula Health has approved the inclusion of additional alert functionality within the Peninsula Health "CLOVER" drug prescribing system. This enhancement ensures that at the time of prescribing Clozapine, CLOVER directs medical staff not registered to prescribe Clozapine to liaise with the mental health services. This function is anticipated to be added when CLOVER undergoes its next upgrade in January 2014.

In addition, Peninsula Health has included information about on Clozapine and the restriction in provision thereof in its 2014 medical intern orientation program.

Response to Recommendation 3:

In relation to the frequency of review of patients in the initial weeks following a transfer from another health service, we note the amendment to the Clozapine (Clopine) Clinical Practice Guideline, addressed in response to Recommendation 1. This amendment requires that staff consider the risk factors for clients in transition from one program to another.

In addition the Peninsula Health Community Mental Health Service Model of Care Clinical Practice Guidelines governs the frequency of review of patients within the community. The Model of Care focuses on the risk profile of patients at all stages of their involvement with the Mental Health Service.

The Peninsula Health Community Mental Health Service Model of Care Clinical Practice Guideline is **enclosed** for the Court's reference (**Enclosure B**).

In addition, we note that all patients newly referred to the community mental health team are added to the team's e-Board (electronic whiteboard) and remain there for daily consideration until the appointment of a Recovery Clinician has been made.

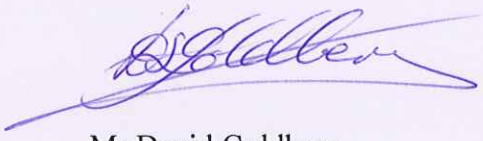
The Community e-Boards Clinical Practice Guideline has recently been amended to more explicitly reflect this in relation to referrals directed from the Peninsula Health triage service.

The Community e-Boards Clinical Practice Guideline is **enclosed** for the Court's reference (**Enclosure C**).

We trust that this is of assistance to the Court.

Please do not hesitate to contact me if you have any queries.

Yours faithfully



Mr David Goldberg
General Counsel
Peninsula Health

Enc.

ENCLOSURE A

CLINICAL PRACTICE GUIDELINE

Peninsula Health

MENTAL HEALTH SERVICE

CLOZAPINE (CLOPINE)

1. INTRODUCTION

Clozapine is used for treatment of Schizophrenia which has been unresponsive to classical neuroleptic therapy. Serious adverse reactions may occur with Clozapine e.g. agranulocytosis, myocarditis, and cardiomyopathy. Given this risk the release of Clozapine in Australia is monitored through a strict distribution system and protocol. This policy outlines the requirements of Peninsula Health Mental Health Service in relation to this system and protocol.

2. PURPOSE

- To ensure clients prescribed Clozapine receive appropriate and necessary monitoring.
- To ensure all Peninsula Health Mental Health Services (PHMHS) comply with the Clopine Connect Protocol, Hospira Pty. Ltd.

3. DEFINITIONS

Clozapine (Clopine)

An atypical antipsychotic agent used for treatment resistant Schizophrenia.
Clozapine is listed as a highly specialized drug, Section 100. (Attachment 1 Clopine Connect Boxed Warning)

NB: At Peninsula Health we prescribe Clopine and register clients with Clopine Connect. Clozapine is also available in other regions as Clozaril.

Clopine Connect Protocol

A mechanism for monitoring patients receiving Clozapine and identifying adverse haematological and cardiac effects

Please note: All documents referenced in this CPG are available on:

M: Drive Current/Clinical Resources/Clozapine/CLOZAPINE DOCUMENTS.

It is necessary to review these documents to ensure Clinical Practice Guidelines are fully adhered to.

4. RELATED POLICIES/CLINICAL PRACTICE GUIDELINES

- Medication Management 6.1.04
- Physical Assessment/Examination
- Information Dissemination for Clients and Carers Clinical Practice Guideline

5 RESPONSIBILITIES

5.1. Employer

The Chief Executive of Peninsula Health is ultimately responsible for ensuring that policy and procedure are implemented to support and guide staff in their practice.

5.2. Departmental

The Clinical Director of PHMHS is responsible for ensuring the Clozapine policy is implemented consistently in the service, and that clinical staff are aware of and have

access to the policy. The Clinical Director is responsible to support and assist the Clozapine Coordinator in the implementation of this policy.

5.3. Department Head/Manager

The Clozapine Coordinator is responsible for the implementation of the Clozapine policy and to ensure all relevant clinical staff are aware of the policy and procedure

5.4. Employee

All relevant clinical staff are responsible for ensuring they are aware of and adhere to this policy during their clinical practice.

6. CLINICAL PRACTICE GUIDELINE

Clozapine Coordinator's contacts numbers:

Inpatient coverage: is the Pharmacist/Clopine Coordinator at Peninsula Health Frankston Hospital 97847603 or 97847197

Community coverage: Clozapine Centre Coordinators at PHCMHS 97846999

Clozapine Coordinator Responsibilities

The Clozapine Coordinator(s), based in the community, are responsible for the implementation of the Clozapine policy and to ensure all relevant and clinical staff are aware of the policy and guidelines.

The Clozapine coordinator(s) will:

- Ensure that PHMHS operates within the Clopine Connect Protocol.
- Record all tests and pathology results on the Clozapine Spreadsheet held on M Drive.
- Provide orientation to Clozapine Guidelines for all PHMHS clinical staff which includes attending orientation of medical staff as advised by Administrative Assistant to Clinical Director of PHMHS.
- Provide education and support to all registered Pharmacies and General Practitioners.
- Monitor Clopine Connect database Monday to Friday to ensure timely response to any variance.
- Advise CLEARS Program Manager of Clopine Connect Protocol or PHMHS Clozapine CPG breaches as soon as practicable.
- Inform PHMHS staff of any changes to the Clopine Connect Protocol.
- Inform PHMHS staff and registered Pharmacies and General Practitioners of any Clozapine CPG changes.
- Provide educational and Clopine Connect Protocol support to clients and carers.
- Facilitate transfer of Clozapine Registrations into and out of area as required. (Consumers transferred on Novartis product or other will be re-registered to Hospira Pty. Ltd. and additional education will be provided).
- Forward copy of *Adverse Drug Event Report* to Hospira Pty. Ltd. Drug Safety Group and Clinical Director of PHMHS following any adverse events related to Clozapine.
- Comply with Protocols between PHMHS and General Practitioners/Private Psychiatrists registered to prescribe Clozapine.
- Ensure all information on Clozapine is current.
- Provide all PHMHS Consultant Psychiatrists and medical staff with a copy of the following documents which can be found as attachments and are available on M:drive

1. Clozapine (Clopine) Connect Boxed Warning
2. PHMHS Clozapine Monitoring: Clinical Guidelines
3. PHMHS Clozapine Commencement Checklist MR/P025
4. PHMHS Clozapine Suggested Starting Schedule
5. PHMHS Weight Range – Psychiatry MR/020 psych
6. Clozapine Physical Observation Chart MR/PO25.2
7. Hospira Adverse Event Capture Form
8. Clopine Abridged Product Information Sheet
9. Clopine (Clozapine) Cardiac Testing and Safety Chart
10. Clopine Connect Monitoring Guide re Haematological Tests
11. Clopine (Clozapine) Drug Interactions Chart
12. Clozapine Guidelines for Emergency Department
13. Clozapine (Clopine) Diabetes Management Chart
14. Clopine (Clozapine) Weight Management Chart
15. MIA Echocardiogram Facilities/Peninsula Catchment area only
16. Pharmacies Registered to Disperse Clopine/ Peninsula Catchment area only
17. Clozapine Shared Care Summary for GP's

In addition, discuss the following:

- The Clozapine Spreadsheet on M Drive
- Clopine Connect Protocol (handout)
- Clopine product information (15 pages handout)

Criteria for Commencing Clozapine

Refer to Clopine Connect Protocol – Introduction (page 3).
Refer to *PHMHS Clozapine Monitoring: Clinical Guidelines* (see attachment 2)

Initiating Clozapine Treatment

The Medical Officer or Consultant Psychiatrist, Clozapine Coordinator and Recovery Clinician and/or Inpatient Staff will provide information to clients and carers, in order to facilitate the provision of education and coordination of Clozapine commencement.

Education of Consumer/Carer

Both verbal and written information must be provided to clients and carers when initiating Clozapine treatment, to ensure they are well informed on the process involved. Information should include:

- Video clip and/or DVD
- Clozapine pamphlets for both client and carer.
- MIMS Consumer Medicine Information Sheet if applicable
- Dietetic advice, referral and information.

Registration

Clozapine clients, prescribing doctors, dispensing pharmacists, centre coordinators and centre must be registered on the Clopine Connect Protocol database; refer to *Clopine Connect Protocol – Registration and roles of centres and personnel (pages 5 - 7).*

MENTAL HEALTH SERVICE
CLOZAPINE (CLOPINE)

Pre-treatment Screening
PHMHS will follow *Clopine Connect Protocol Pre-treatment Screening recommendations (Clopine Connect Protocol page 4 – Pre-treatment Screening).*
Refer to PHMHS *Clozapine Guidelines: Clinical Monitoring* (Attachment 2).
Refer to *Clopine Abridged Product Information Sheets* (Attachment 8)
Refer to *PHMHS Clozapine (Clopine) Commencement Checklist* (Attachment 3)

Commencing Clozapine
Refer to *Clopine Connect Protocol page 7 - 14 – Commencing Treatment.*
Refer to *PHMHS Clozapine Guidelines: Clinical Monitoring* (Attachment 2).
(Community based commencement should occur on a Tuesday or Wednesday)
Refer to *PHMHS Clozapine (Clopine) Commencement Checklist* (Attachment 3).

Responsibility of Medical Officer
- Complete relevant section of *Clozapine (Clopine) Commencement Checklist* (Attachment 3).

Clopine Patient Number (CPN)
- CPN will be generated by Hospira Pty. Ltd. for that consumer. (Notification of registration takes 24 hours.)
- This number must be recorded on all subsequent Clopine Connect Protocol Blood Count Forms. To ensure consumer privacy, this number is the only identifier used by Hospira Pty. Ltd.

Copy of Forms
- To be filed in client's clinical record.

Location of Clozapine Commencement
- Hospitalised clients must be commenced within easy access to resuscitative equipment, specialled for 6 hours, and then reviewed by a Consultant or Senior Medical Officer.
- Community clients are to be specialled for 6 hours in the ECT suite, within easy access to resuscitative equipment, and then reviewed by a Consultant or Senior Medical Officer. The Nurse Special in the ECT Suite must have a 2 West Duress Alarm due to isolation.
- A registered nurse (Division 1) is employed for six hours the booking of this clinician is to be discussed with the CLEARS Program Manager.

Day Prior to Commencement for Community Treatment
The Recovery Clinician is responsible for ensuring the client's FBE has been completed, that it is satisfactory as per **Clozapine Guidelines i.e. green range and time frame.**

Clozapine Coordinator (Community) and/or Recovery Clinician will attend pharmacy with current blood count form and script for the commencement of medication schedule via blister pack dispensing.

Day of Commencement for Treatment

- Inpatient – treating Medical Officer/ Registrar/Unit Manager and hospital based Clozapine Coordinator to initiate.
- Community commencement – Clozapine Coordinator (Community) and Recovery Clinician will accompany client to the ECT Suite with blister pack for Clozapine observation.

Responsibility of Nurse Special (Registered Nurse) during Commencement of Clozapine

The nurse will:

- Know the location of and use of resuscitation equipment.
- Have on their possession Ward Duress Alarm.
- Record base line heart rate, respiratory rate, temperature and blood pressure. These are recorded every 15 minutes for the first hour, then hourly. These are recorded on the *Clozapine Physical Observations Chart (MR/P025.2)* (Attachment 6).
- For both inpatients and community clients the nurse will record medication administration on *Psychiatric Drug Therapy Chart MR/13A*. Documentation will be filed in clinical file.

Day Two and Three after Commencement of Treatment

Both inpatient and community clients to have their Blood Pressure, temperature, pulse, respirations taken approximately one hour after mane dose.

Following Appointments in Community

The client is provided with pathology slips for blood tests (FBE and Troponin I), and medical appointments as per the Clozapine Monitoring: Clinical Guidelines.

Maintenance of Clients on Clozapine

Monitoring

Refer to:

- Clopine *Connect Protocol page 11 -16 - Hematological monitoring during therapy with Clopine*
- *PHMHS Clozapine Guidelines: Clinical Monitoring* (Attachment 2)
- *Clozapine Commencement Checklist* (Attachment 3)

Clinical Assessments

Refer to *Clopine Connect Protocol pages 10 - 16 and PHMHS Clozapine Guidelines: Clinical Monitoring* (Attachment 2).

Clients will be seen by a Medical Officer for a clinical assessment (infection, side effects, mental state) within 48 hours of blood collection.

Blood Glucose Level (BGL) and Lipid Studies

Will be monitored according to PHMHS *Clozapine Guidelines: Clinical Monitoring* and *Clopine (Clozapine) Diabetes Management* (Attachments 2 &13)

Cardiology

- Refer to PHMHS *Clozapine Guidelines: Clinical Monitoring* (Attachment 2).

- Refer to ***Clopine Connect Protocol pages 3, 31, and 32 – Special note: myocarditis***
- Clozapine Coordinator will ensure that due dates for echocardiograms have been recorded on the Clozapine Spreadsheet (M: Drive).

Dosage

- Refer to ***Clopine Connect Protocol pages 10 - 16 – Dosage of Clopine***
  Dosages equivalents are the same for Clopine and Clozaril,
  I.e. Clopine 200 mg nocte = Clozaril 200 mg nocte.
- Refer to *PHMHS Clozapine Suggested Starting Schedule* (Attachment 4).

Clozapine Plasma Levels

Clozapine serum levels to be ordered as clinically indicated.

Interruption to Clozapine Therapy/Recommencing Clozapine Therapy

- Refer to *Clopine Connect Protocol page 15 - 16 – Restarting therapy after discontinuation / Recommencing therapy after interruption / Haematological monitoring after interruption of therapy.*
- Refer to *PHMHS Clozapine Guidelines: Clinical Monitoring* (Attachment 2).
- Refer to *Clopine Connect Monitoring Guide re Haematological Tests* (Attachment 10)
- Refer to *PHMHS Clozapine Suggested Starting Schedule* (Attachment 4)

Discontinuing Clozapine Therapy

- Refer to *Clopine Connect Protocol page 15 – Discontinuing Therapy.*
- The treating doctor must notify Clozapine Coordinator by phone or facsimile within 24 hours and complete *Clopine Connect Protocol –Therapy Event Form page 30.*
- An *Adverse Drug Capture Event Form (Hospira)* from Hospira Pty. Ltd. Drug Safety Group will be sent to the treating staff to be completed and returned if a client has ceased for reasons other than non-compliance or inadequate response (Attachment 7).

Transferring Clients to another Centre

- Refer to Clopine Connect Protocol page 17 – Transferring a client to another centre.
- Medical Officer and/or Recovery Clinician to inform Clozapine Coordinator as soon as practicable of intended transfers.

Receiving Clients from another Centre

- Clients will be referred for community follow up via triage in the usual way and will be contacted by the community team within 72 hours to arrange an appointment, frequency of contact will be planned with consideration of the increased risk a client may present during the period of transition
- In most situations the Clozapine Coordinator will be notified of the transfer by the referring Clozapine Centre however the receiving team is to liaise with the Coordinator to confirm this has happened
- Clozapine Coordinator to contact the referring centre to identify the date of and amount of medication from last prescription and the date of the next pathology and required medical view with the referring Clozapine Centre and confirm same with the receiving team

NB: Clients transferring from other regions may have been managed on CLOZARIL, in that case the referral should be accompanied by a form transferring from CLOZARIL TO CLOPINE. Should this not be the case please liaise with the referring centre to receive same. As a reference please review the Clopine Connect Protocol (page 25), a copy of which is given to each prescribing medical staff member as well as available in each team and liaise with the Clozapine Coordinator for appropriate transition to CLOPINE. The Clozapine Coordinator will coordinate registration of the client with CLOPINE CONNECT

Reporting Requirements of Registered Community Pharmacies

Registered Community Pharmacies are required to forward a list of client names and the number of tablets dispensed to Peninsula Health Pharmacy Department at the end of each month.

Refer to *Pharmacies registered with Clopine Connect Program* (Attachment 16).

PH Incident Report

A VHIMS entry will be completed by the Clozapine Coordinator when Clopine Connect Protocol is not adhered to or as issues are identified. This information will be reported to Program Manager as soon as practicable.

Referring to GP for Shared Care (Clozapine Treatment and Monitoring)

Criteria for Shared Care (Clozapine Treatment and Monitoring)

The following criteria will be used by PHMHS treating Medical Officer and Clozapine Coordinator to determine suitability for shared care.

Client is:

- Functioning at their maximum level.
- Suitable for monthly monitoring.
- Stable mental state, pathology and Clozapine regime.
- Compliant with treatment and attends all appointments punctually.
- Willing to be transferred to GP.
- Aware that they will not be discharged from PHMHS.

The Clozapine Coordinator must ensure the GP has a copy of the following:

- *Clozapine Shared Care Summary for GP's* **(to be completed by the Community Clozapine Coordinator in consultation with the Recovery Clinician)** (Attachment 17)
- Clopine Connect Protocol
- *Clopine Abridged Product Information and/or Full Product Information* (Attachment 8)
- *Clopine (Clozapine) Cardiac Testing and Safety Chart* (Attachment 9)
- *Clopine (Clozapine) Drug Interactions* (Attachment 11)

- *Clozapine (Clopine) Boxed Warning* (Attachment 1)
- *Clozapine (Clopine) Diabetes Management (optional)* (Attachment 13)
- Echocardiogram Reports

Presentation of Client to Emergency Department

Refer to PHMHS *Patient on Clozapine (Clopine): Guidelines for Emergency Department* (Attachment 12).

7. EVALUATION

Completed Incident Report following any adverse reaction

- Formal policy review

8. REFERENCES

- Clopine Connect Program Protocol
- National Standards for Mental Health Services – Standard 10 – Provision of Care
- EQuIPNATIONAL – Standard 12

Helpful Contacts

Name	Telephone	Facsimile
Clopine Connect Program www.clopine.com.au	1800 656 403	1800 657 454
Consultant Hematologist and Cardiologist	1800 656 403	
Hospira Medical Information	1300 346 774	

9. CLINICAL PRACTICE GUIDELINE HISTORY

This CPG replaces the Peninsula Health Psychiatric Service *Clozapine* policy created January 2004, reviewed June 2011 and March 2013.

10. KEY PERFORMANCE INDICATORS/OUTCOME

ENCLOSURE B

CLINICAL PRACTICE GUIDELINE

Peninsula Health

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

1. INTRODUCTION

In 2006, The Council of Australian Governments identified a need to implement 'best practice' for community care as a priority area for Mental Health (BCG Report, Victorian DHS, and July 2006). PHMHS conducted a systematic review of standard treatment and found issues of poor access for consumers, poor communication with carers and other referrers, difficulties in communication between parts of the service, and a lack of primary services (e.g. G.P.) or other supports involved in a client's care beyond discharge. In addition, standard care was not clearly defined and only 30% of clinical files had focus on specific 'evidence-based' therapeutic interventions. Like many services, the use of interventions was found to be ad hoc or dependent on the individual clinician's level of expertise, interest and training. There were few clearly articulated expectations about adherence to minimum standards of 'best practice'. This finding was consistent with international evidence that says, despite the knowledge that adhering to 'best practice' leads to better outcomes for consumers, there is little evidence that Mental Health Clinicians are consistently offering what constitutes 'best practice' to consumers (Drake et al., 2001;Higgitt & Fonagy, 2002; Jones et al., 2006).

2. PURPOSE

Peninsula Mental Health Service developed a service strategy that aims to significantly improve consumer outcomes. The purpose of the guideline is to support the change in practice to ensure that individuals referred to the service who are experiencing a serious mental health crisis or a relapse of a mental illness have easy and seamless access to treatment and support based on their "meetable" needs, and that the core treatments given to consumers are primarily interventions with demonstrated effectiveness (Evidence-based Practice) which are standardised and delivered in a targeted and systematic fashion to maximise recovery and enhance autonomy.

3. DEFINITIONS

"**Meetable needs"-** PMHS recognises that although we advocate for all consumers to have access to the treatment for core needs, on some occasions some of the needs may not be meetable (client refusal) or may not be directly meetable by our service (e.g. accommodation, employment etc).

Integrated teams- Adult Community Treatment comprises four Teams based on four geographical areas. Each Team is responsible for providing a targeted, appropriate, and efficient response to referrals and ensuring treatment is delivered in a timely, focused and flexible manner

Assertive Community Treatment- Assertive Community Treatment also targets individuals experiencing acute psychiatric symptoms. The team is responsible for the provision of ACT, which is intensified for consumers who are acutely unwell.

Easy Access- Easy in: Our service is set up to give consumers access and support as soon as possible in order to minimise the effects of illness and promote a quicker recovery.

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

Easy out: To empower consumers to manage their own mental health. This may include the provision of PMHS directly for a short period and the support of a GP, a private Psychiatrist, Psychologist, or other Community based Services for a longer period.
Easy back in: If consumers need further help from us after discharge the consumer, family member and/or nominated person/s are encouraged to recontact us and we provide support as soon as possible.

Core Care Bundle: The Core Care Bundle was developed from Evidence-Based Practice and forms the basis of essential treatment to be offered to all clients once basic safety is achieved.

Care Planning: Care planning is a collaborative, coordinated, person-centred care process that ensures that consumers of Peninsula Health receive quality services that meet individually assessed needs and goals.

Care planning for the provision of treatments and interventions at PH is informed by the consumer assessment, involves a biopsychosocial and multidisciplinary approach, conducted in a comfortable and caring environment and ensures that the expertise and skill of carers is actively sought and informs the care to be provided.

Care planning within PH incorporates access to a range of safe effective treatments and interventions that are evidence-based, reflect internationally accepted standards of practice, and are conducted by appropriately qualified and experienced health professionals. Planning for ongoing care following discharge should include a comprehensive treatment plan to reduce the risk of unplanned re-admission/ re-entry to PH and often involves partnerships with other professionals and care/service providers in the community.

4. RELATED POLICIES/ CLINICAL PRACTICE GUIDELINES

National Standards in Mental Health Service: Standards in Service Delivery (Standard 11.4.D)
Peninsula Health Mental Health Service Guidelines: Evidence-based Treatment for Borderline Personality Disorder

5. RESPONSIBILITIES

5.1. **Employer** - Details the responsibilities for ensuring that the Clinical Practice Guideline is adhered to.

5.2. **Departmental** - Details the responsibilities of the Department/Unit involved, e.g. assisting Department Heads to enforce the Clinical Practice Guideline.

5.3. **Department Head/Manager** - Consultant Psychiatrists and Team Managers

- Support the change to more assertive and targeted treatment
- Advocate for adequate resources to implement service change
- Provide expertise at targeting the appropriate treatment
- Develop a system for treatment planning and delivery

- Adhere to a checklist of factors and outcome variables used to monitor program

5.4. **Employee** - Details the responsibilities of all employees in relation to the Clinical Practice Guideline, including compliance with the Policies and Clinical Practice Guidelines.

Expectations of Clinicians

Assessment

- Physical, social & psychological domains are comprehensively assessed and addressed
- Collateral history and account from other treating agencies is obtained

Engagement

- The clinician works to ensure that the individual is available for planned follow up 75% of the time
- The clinician and team are available in a timely manner for individual needs and issues
- Rapport, honesty and mutual respect are goals of treatment
- The clinician has a knowledge of the individual's environment and social context
- With consent, the clinician regularly engages family and caregivers, who feel supported and informed

Treatment

- Treatment is undertaken in an episodic fashion with an "easy in, easy out" approach
- Clinicians ensure that treatment occurs in the most advantageous milieu in the least restrictive fashion
- The clinician and team intervene early and apply targeted and continuous treatment
- The individual is on optimal medication, with reduced suffering and maximal functional gain with the eventual goal being remission
- The individual is advised of the pros and cons of treatment. Side effects are reviewed and minimised
- Clinicians regularly check compliance through pill counts and carer accounts, as well as verbally with the individual. Treatment non-adherence is actively addressed
- Clinicians, in situations of acute & ongoing need, maintain at least 2nd weekly contact with the individual
- Treatment utilises both evidence-based and innovative approaches

Recovery

- Counseling utilises empathic & reflective listening to foster hope in recovery
- Rehabilitation is person-centred and organised around the individual's stated issues and goals. Areas of concern are recognised to be the cornerstones of collaboration and are explored and engaged
- A rich, non clinical, parallel, narrative of recovery is encouraged in the individual. This account incorporates a sense of well being, empowerment, confidence and self-worth through engagement in work, life activities and social linkage. Strengths are fostered
- The individual is assisted in moving toward a vocation, or else engaged in work

Safety

- Clinicians have a day by day sense of the safety of the individual

- Risk assessments are regularly performed and steps are taken to ensure maximum safety

Co morbidity

- The individual has had education around anxiety management and is able to practice breathing control and progressive muscular relaxation
- Drug & alcohol issues have been identified and motivational interviewing has taken place around this

Physical Health

- The individual has a comprehensive physical health review and examination each six months
- Weight and metabolic parameters are measured at least six monthly, as are AIMS *(need chart for this)*
- Individuals are encouraged to improve health through exercise, a healthy diet and smoking cessation

Documentation

- Case notes, collaboration plans, clinical summaries & other forms are used as practical tools and are updated regularly and for each clinical review meeting

Education

- The individual and family have had a thorough education about all aspects of the illness working to increase insight, knowledge and early action on relapse

Social Infrastructure

- Clinicians ensure that accommodation is adequate to the person's needs
- Clinicians ensure that a stable income is available to the individual
- Individuals and families are offered options for community support

Social inclusion

- Issues of stigma are discussed in a supportive manner
- All efforts are being made to enhance the individual's inclusion in society

External Agency Linkage

- Options for parallel or sequential care are explored for the advantage of the individual

Discharge

- Discharge is planned to continue optimal treatment in the simplest manner possible
- A comprehensive handover is made to receiving agencies

6. CLINICAL PRACTICE GUIDELINE - Summary

- **Defining Structure and Functions within Community Teams (Integrated Teams)** leading to greater continuity of care for consumers and increased collaboration within teams and between other parts of the service
- **Change in Consumer Journey (Easy Access)** leading to more specific and targeted short-term treatment goals based on **"meetable" needs** leading to shorter episodes of treatment but easier access back into the service.

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

- **Provision of Assertive Community Treatment (ACT)** leading to improved collaboration with consumers and a reduction in rates of involuntary treatment.
- **The implementation of a comprehensive Evidence-based treatment program** Core Care Bundle with clearly defined minimum standards of acceptable treatment leading to greater levels of adherence to Evidence-Based Practice in the service by clinicians.
- **Access to specialised psychosocial therapy** either within the service or if possible, in the community, leading to improved outcomes, increased autonomy for consumers and shared care with other health professionals.
- **Facilitating Stronger Partnerships** with PDRSS and NGOs leading to increased access to these services for consumers

Defining Structure and Functions within Community Teams (Integrated Teams)
Adult Community Treatment comprises four Teams based on four geographical areas. Each Team is responsible for providing a targeted, appropriate, and efficient response to referrals and ensuring treatment is delivered in a timely, focused and flexible manner based on "meetable" needs. The Consultant Psychiatrist and the Team Manager lead the team in determining the appropriate response and who (and how many) on the team could best provide a service to a particular consumer. The rostered staff provides services after-hours.

The total numbers for which a team can provide services will be affected by the acuity of the consumers and the flexibility of treatment provision. If the ratio is too high the team find themselves reacting to crises rather than helping consumers take proactive steps. More links with GPs, Specialists, PDRS, or other service providers result in the ability to provide more assertive treatment to those that require it.

The Mental Health Clinician is selected to best match a consumer's needs. Team members will have different skills and experience that are invaluable to consumers. While everybody on the team needs to have some degree of skill in most areas, all clinicians have the opportunity to provide specialised interventions according to their professional background or expertise.

The less specialised tasks such as going shopping, taking consumers to appointments, dealing with Centrelink etc, are to be provided whenever possible by rehabilitation assistant or an external agency such as a PDRS worker, mentor from the Mentors/Helpers program, or other, unless there is a documented plan for the provision of such services.

All Teams provide the following services:

- Assertive Community Treatment (ACT)
- Early Psychosis Service
- GP liaison-PMHS/Early Intervention
- Links with GPs
- Links with PDRS
- Provide more links to specialised psychosocial Evidence-Based interventions either within the service or in the community
- More clinic-based work

- Seamless transition between parts of service
- Improved communication both within teams and between parts of the service

Consultant Psychiatrists and Team Managers

- Support the change to more assertive and targeted treatment
- Advocate for adequate resources to implement service change
- Provide expertise at targeting the appropriate treatment
- Develop a system for treatment planning and delivery
- Adhere to a checklist of factors and outcome variables used to monitor program
- Celebrate every small success

Role of Psychiatric Medical Officers or Registrars

- Provide a comprehensive biopsychosocial assessment
- Prescribe treatment and monitor effectiveness
- Attend to treatment side effects
- Provide input to optimal physical and mental health
- Work with the team to foster recovery and rehabilitation

Role of Mental Health Clinician

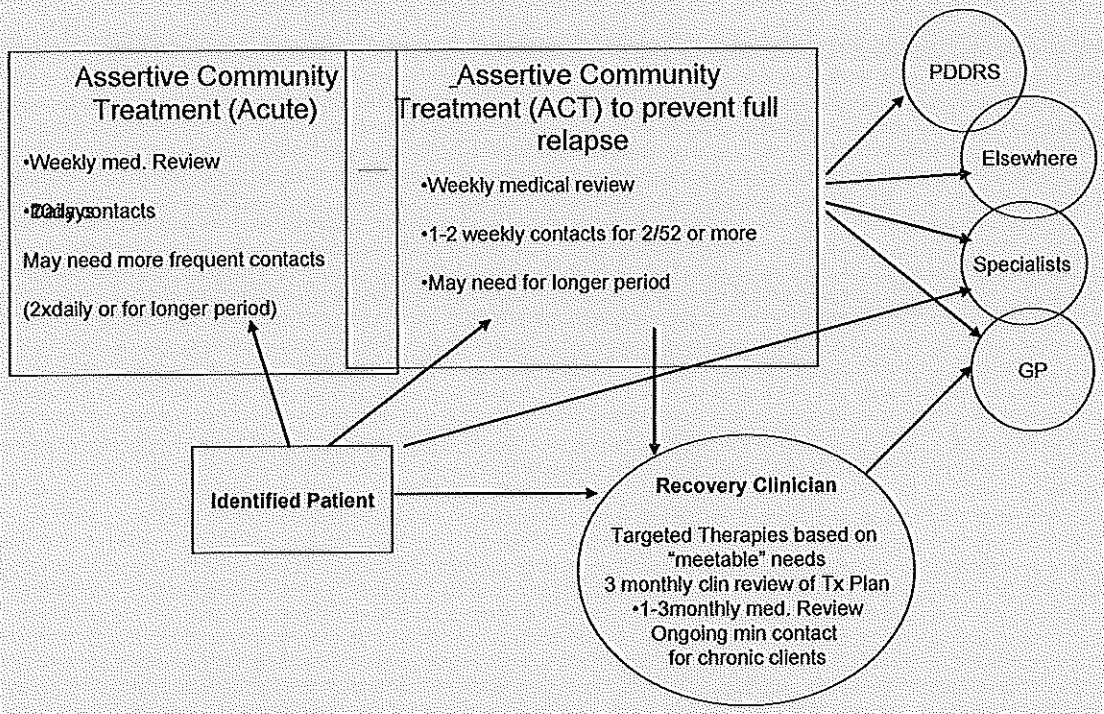
- Provide a comprehensive biopsychosocial assessment
- Assessing the consumers status and "meetable" needs
- Developing a collaborative treatment plan with the consumer and including family if possible
- Provide access to services both within and external to PMHS
- Organise medical care
- Coordinate care across the broader team
- Make the linkage with GP and other community services

Change in Consumer Journey (Easy Access) and Service Delivery (based on Meetable Needs)

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

Peninsula Community Mental Health Service Treatment



It is the goal of PMHS to provide easy access to consumers, family, and others. With a principle of "no refusal" all referrals are responded to on the basis of need and optimal care. There is a seamless provision of communication and care between the point of triage and other parts of the service.

PMHS recognises that although we advocate for all consumers to have access to the treatment for core needs, on some occasions some of the needs may not be meetable (client refusal) or may not be directly meetable by our service (e.g. accommodation, employment etc).

Easy in: Our service is set up to give consumers access and support as soon as possible in order to minimise the effects of illness and promote a quicker recovery.
Easy out: To empower consumers to manage their own mental health. This may include the provision of PMHS directly for a short period and the support of a GP, a private Psychiatrist, Psychologist, or other Community based Services for a longer period.

Easy back in: If consumers need further help from us after discharge the consumer, family member and/or nominated person/s are encouraged to recontact us and we provide support as soon as possible.

Easy In: Shorter episodes-based on "meetable" needs

- Comprehensive and Cumulative Assessment
- Needs assessment (are the needs meetable?)
- Risk assessment and management
- Compliance monitoring
- Psychoeducation with client/family
- Core Care Bundle (includes core care booklets)
- Variable links with PDRS/GP
- Links made to Private psychiatrists/psychologists
- Relapse Prevention

Recover-partial/complete

- Further "meetable" needs assessment
- Some with ongoing need for contact re medication/CTO
- Some with ongoing need for contact re medication/CTO but with PDRS support
- Some transferred to GP, GP & PDRS, private psychiatrist/psychologist or other

Relapse

- Return quickly
- Assertive Community Treatment
- Add to cumulative clinical assessment
- Act on further needs assessment
- And so on

Assertive Community Treatment (ACT)

Assertive community treatment was developed in Madison, Wisconsin, in the early 1970s in response to the recognition that many patients experienced repeated re-admissions to hospital (Phillips et al., 2001). The goal of ACT was to reduce the inevitability of re-admissions by providing a targeted treatment for individuals experiencing severe psychiatric symptoms with associated possible non-compliance with medication, medical problems, unstable living conditions, financial and legal difficulties, risk taking behaviours such as drug and alcohol abuse or unsafe sexual practices, and few, if any, additional supports. ACT aims to lessen or eliminate the debilitating symptoms of mental illness the individual experiences and minimize or prevent recurrent acute episodes of the illness and to satisfy basic needs and enhance quality of life (Smith & Newton, 2007).

Assertive Community Treatment also targets individuals experiencing acute psychiatric symptoms. The team is responsible for the provision of ACT, which is intensified for consumers who are acutely unwell.

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

The consumer receiving a service becomes engaged with the team and not just one person. The primary clinician does take primary responsibility for a given consumer but other members know the consumer and the absence of a team member doesn't become the basis for a dramatic upset. Other designated team members share tasks related to coordinating care and are responsible to perform them when the primary clinician is absent. The whole team is involved in the exchange of information and treatment management. Having regular reviews of consumers provides an opportunity for all members of the team to provide input and assume responsibility for each consumer undergoing treatment.

Differences between ACT and Intensive Case Management

Intensive case management involves assertive outreach by a single case manager with small caseload ratio. The case manager provides a range of services that are less intensive and not as standardized as the assertive community treatment model. Intensive case management was designed for persons with severe mental illness who are either high service users or not using traditional mental health services at all. Viewed by some as an adaptation of the assertive community treatment model, intensive case management combines the principles of case management (that is, assessment, planning, linking to services, monitoring, and advocacy) with a low staff-to-consumer ratio, assertive outreach, and direct delivery of services. Intensive case management, however, lacks a team approach and does not have a validated program model that specifies necessary ingredients to ensure faithful program implementation. Instead, individual programs have had to develop their own approaches (Meyer & Morrissey, 2007).

Assertive Community Treatment-Research Findings

Cochrane Review 2007: Assertive community treatment for people with severe mental disorders (Marshall & Lockwood, 1998)
Overall, ACT is viewed as an effective way of treating those with a severe mental illness and results in some improvements such as reducing hospital admissions and is highly acceptable to consumers. In particular, ACT has been found to be most appropriate for the consumers with the most intractable symptoms and greatest functional impairment resulting in poor quality of life and heavy use of inpatient services (Phillip et al., 2001).

- ACT increased those maintaining contact with services compared to standard care
- Decreased number of hospital admissions
- Decreased length of time in hospital compared to standard care and case management.
- Significant and robust differences between ACT and standard care were found on accommodation status, employment and patient satisfaction.

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

Variations of ACT implementation
ACT has been implemented in countries such as America, Canada, England, Sweden, and Australia over the past 30 years. Investigations have indicated significant variation of adherence to the ACT model by services to meet local needs (McGew et al.), especially in terms of some of the original components such as 24 hour coverage, in vivo services, direct provision of ACT by staff, and the extent that teams shared a common caseload.

According to McDonel et al. (1997), structural, financial, staffing, and geographic issues can affect full ACT implementation. The difficulties due to the potential for higher cost compared to case management may be overcome by providing ACT only to frequent users of inpatient treatment or by transferring funding from less effective case management. In general programs aim to adapt elements of the model enough to overcome the challenges but still provide an effective ACT component.

Specific service content provided or coordinated by ACT:

- Medication support
- Rehabilitative approach to daily living skills
- Family involvement
- Access to work opportunities/financial management
- Housing assistance
- Health promotion (medical screening)
- Problem orientated counselling approach

Although research suggests that ACT has been greatly modified, there are common features of interventions found to be associated with reduction in hospitalisation (Burns & Catty (2002)

- Regular sessions
- Responsibility for health and social care
- Lower case loads
- Multidisciplinary teams
- Psychiatrist on team

According to a survey of case managers perspectives on the specific effective elements of ACT delivery (McGrew, Pescosolido, & Wright, 2003), the following were considered the most critical elements:

- Multidisciplinary team
- Focus on medication adherence
- Team approach (Shared caseloads, treatment planning, daily meetings)
- Team involvement in hospital decisions to admit and discharge consumers
- Community outreach
- Ongoing assessments

Overall, specific elements related to good outcomes in ACT (Phillips et al., 2001) compared to alternative approaches include:

- Assertive engagement

- Small caseload (1:10-1:20)
- Team approach (Shared caseloads, treatment planning, daily meetings)
- Explicit admission criteria (actively recruit a defined population)
- Outreach service provision

Assertive Community Treatment at Peninsula Mental Health Service

As ACT has accrued a long research history with a refinement over time of some of the essential principles and content of service provision required to produce an effective outcome, the particular ingredients deemed to be important components for ACT for PMHS include:

- Focus on medication adherence
- Team approach (Shared caseloads, treatment planning, daily meetings),
- Assertive outreach to difficult to engage clients
- Team take responsibility
- Ensuring appropriate medication at the appropriate dose both for the underlying illness and any agitation.
- Correct Diagnosis and formulation
- Addressing substance abuse or any other behaviours that may be precipitants
- Providing the consumer with access to services able to provide basic needs such as food and shelter.
- Frequent face to face contact
- Psychoeducation
- Family involvement where possible
- Frequent Medical reviews

Focus of Assertive Community Treatment

The priorities of treatment for consumers experiencing an acute episode of Mental Illness are assessment, medical interventions and short-term assertive treatment. The goal of ACT is to provide a high level of short-term treatment that is assertive, reducing risk and averting hospital admissions. Clinicians are expected to make greater, albeit selective, use of the mental health clinic as a daytime site for acute assessments. Although rostered staff members are responsible for the provision of after-hours care, every member of the team is responsible for the provision of ACT.

There is no perfect path to recovery. However, non-compliance with medication is one of the major factors associated with relapse and chronic poor mental health and placement on Involuntary Treatment Orders. The major focus of ACT is to work proactively with the consumer to trial multiple medications in order to increase potential to take medication. Motivational interviewing is used as a primary tool in attempting to increase the motivation of an individual to take medication.

ACT is focused on teaching consumers to be more independent and how to manage their symptoms, advocate for themselves, and take charge of their recovery. Consumer choices are respected and focus work on other issues such as housing etc basic needs (Maslow's

hierarchy-food, clothing, shelter, and safety) and work toward stability in needs and mental state, followed by achieving collaboratively determined goals. Until there is some basic achievement of stability, assertive treatment will be required with multiple clinicians involved. As consumers achieve a level of recovery, psychiatric services are gradually withdrawn, although care coordination may be provided by other organisations such as PDRS.

The primary goal of service provision is to treat consumers in the least restrictive environment. Signs of relapse are an indication that the team response is to be intensified and the consumer assertively treated in the community. An inpatient admission is to be avoided and only used as a last resort. If an unavoidable admission occurs, the goal for the team is to make the transition as smooth as possible by adequate communication and transfer of information to assist the admission process, to keep resources such as housing in place, and to be in communication with the ward to enable adequate coordination of treatment and for discharge planning.

Focus of ACT: More Intensive to Less Intensive

- Team take responsibility
- Frequent monitoring of mental state
- Ensuring appropriate medication at the appropriate dose both for the underlying illness and any agitation.
- Correct Diagnosis and formulation
- Addressing substance abuse or any other behaviours that may be precipitants
- Providing the consumer with support to maintain basic needs such as food and shelter.
- A minimum of daily face to face appointments.
- Psychoeducation
- Family involvement
- Phone contacts may be part of the plan but are not in lieu of face to face contacts
- Medical reviews weekly
- Treatment provided for up to 10 days (May need more frequent contacts e.g. 2xdaily or for longer period)

Less intensive follow-up occurs when a consumer's mental state is somewhat stabilised, reducing the time from daily to once or twice a week. During the next phase of treatment, linkages are made for treatment and/or support to GPs, Specialists, PDRS, or elsewhere, and further psychoeducation about the illness is provided to consumers and their carers.

- Linkage on
- Persevere when consumers don't engage with treatment (Don't take "No")
- 1-2 weekly contacts for 2/52-6/52
- Weekly medical review
- May need for longer period

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

The Outcome of Assertive treatment for an individual:

- More engaged in treatment
- Increase in capacity to work
- Psychiatric symptoms under their control with our help and without recourse to inpatient admissions
- Supported by community services when needed
- Increased support for family

Comprehensive Evidence –based treatment program (Core Care Bundle)
The Core Care Bundle was developed from Evidence-Based Practice and forms the basis of essential treatment to be offered to all clients once basic safety is achieved. The Bundle is supported with consumer focused education booklets to be used as a basic guide to treatment. The core bundle is deemed to be a Minimum Standard of treatment for all consumers of PMHS and is outlined on the Individual Treatment & Recovery Plan. All consumers are informed through consumer brochures and on the Treatment Plan about the core care provided by the service, the process of treatment and the expected outcomes. Consumers are involved in the treatment planning process whereby the prospective treatments available to them are articulated and their needs and goals are assessed and documented with a clear plan developed.

The Individual Treatment & Recovery Plan provides details of specific interventions or services that will be provided, by whom, for what duration, and where each service will be provided. Progress notes demonstrate fidelity to goals and treatment outlined in the Treatment Plan and informs of changes to the plan when a new need arises. The checking off and dating of core care booklets corresponds with the date of treatment documented in the consumer's case notes. This includes the adequate and clear documentation of any reasons for parts of the Core Care Bundle not being met. The Plan may be presented to the team for further input and is translated into a schedule of services for a consumer.

Core Care Bundle

- Thorough and cumulative diagnostic assessment which includes the development of a formulation (predisposing, precipitating, perpetuating, protective factors).
- Comprehensive Risk assessment and adequate Risk Management Plan developed and updated
- Information/education about illness and Relapse and Prevention Plan developed (**Toward Recovery booklet**)
- Information about medication. Correct medication at the correct dose & adequate monitoring by specialist **(Managing Medication booklet)**
- Communication/information/education for family/friends **(Carer Pack)**
- Thorough substance use assessment. Assistance with Drug & Alcohol problems/Motivational Interviewing/referral to drug and alcohol service **(Addressing Substance Use booklet)**
- Ensuring a link with GP, regular physical monitoring and encouraging Healthy Living **(Healthy Living booklet)**
- Assistance with Stress Management **(Stress Management booklet)**

- May need links to support with basic needs such as food and housing
- May need referral to other agencies or specialists for further assistance with psychosocial goals

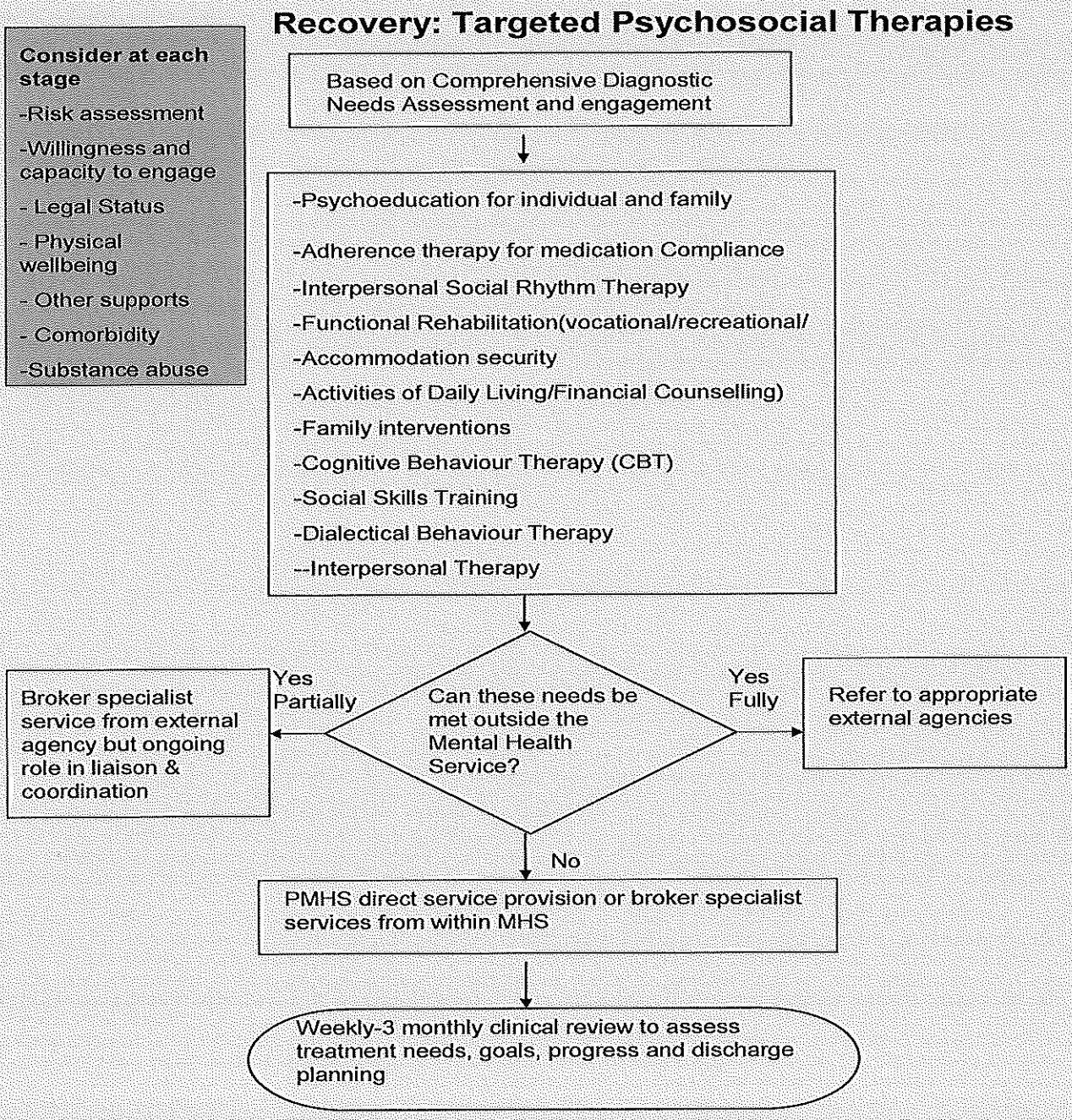
Evidence-Based Psychosocial Treatment

Clinical governance charges mental health organisations with a duty to seek quality improvements to health care and to provide access to a range of safe and effective psychosocial therapies that are evidence-based, reflect internationally accepted standards of practice, and are conducted by appropriately qualified and experienced mental health professionals (Higgitt & Fonagy, 2002). Current best practice for psychosocial treatments usually include an integrated biopsychosocial approach, as it is considered that no domain of intervention can achieve optimum change in isolation. This approach requires interdisciplinary teamwork and partnerships with other professions and non-professionals. Further, psychosocial interventions aim to integrate consumers into the local community and attempt to maximise natural and current supports. This necessitates ongoing collaborative relationships with consumers, carers, and others.

The selection of appropriate and effective psychosocial treatments needs to be driven by the circumstances of the individual consumer's needs. Specific psychosocial therapies offered or recommended by PMHS for individuals are based on the best available evidence. In general, PMHS attempts to refer out to other agencies whenever possible and the extent to which clinicians at PMHS directly provide these therapies is defined by the assessed needs of the clients and the availability of the appropriate services in the community.

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE



PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

Factors that may impact on the consumers' ability to benefit from interventions:
When offering or initiating specific psychosocial therapies to a consumer, considerations must be given to the following factors that may have an impact (directly or indirectly) on the consumers' ability to benefit from interventions. As a result, a particular consumer's needs may not be "meetable" by PHPS at a given time. In addition, a consumer's needs may be met by others such as private psychiatrists, psychologists, General Practitioners, PDRSS, and others. In many cases the links for treatment with others may be more beneficial as it increases sense of autonomy.

- **Risk (suicide & aggression)**

The presence of suicidal ideation requires a thorough risk assessment (using risk assessment form), particularly if there is any question about a consumer's suicidal intent, prior suicide attempts, or current depressed mood, as suicidal ideation can be predictive of a subsequent suicide attempt in schizophrenia. Identifying risk factors for aggressive behaviour include prior aggressive episodes, and the risk increases with comorbid substance abuse, antisocial personality, or neurological impairment. Comprehensive Management Plans may be developed to include warning signs and specific contingency plans for risk and may include collaboration from the consumer and family members.

- **Phase of Illness**

Phases of Illness include an acute phase, defined by an acute psychotic episode, and a recovery phase. The goals of treatment for the acute phase are to prevent harm, reduce disturbed behaviour, and provide relief from the symptoms of psychosis and associated symptoms (e.g., agitation, aggression, negative symptoms, and affective symptoms). Additional goals are to develop a therapeutic engagement with the consumer and family, formulate short- and long-term treatment plans, and connect the consumer with appropriate aftercare in the community. During the recovery phase, the goals are to treat remaining psychosis or other symptoms (e.g. anxiety or depression) and to address any ongoing disruption to vocational functioning and relationships, to develop a relapse profile and to enhance the consumer's adaptation to life in the community.

- **Willingness & Capacity to Engage**

A strong therapeutic alliance forms the foundation on which treatment is established and maintained. Research indicates that specific attention in the therapeutic relationship to identifying the consumer's goals and aspirations and relating them to treatment outcomes increases treatment adherence. Legal Status can affect the engagement process. It is important to attempt to develop engagement with the family and other significant support persons, with the consumer's permission.

- **Co morbidity**

A number of psychiatric conditions occur frequently in persons with schizophrenia. Each of these conditions deserves attention and possibly treatment in its own right, with such treatment concurrent with that for schizophrenia.

- **Physical Health**

Consideration of the consumer's past medical history and general medical status is essential, as certain illnesses, such as diabetes, are more common in persons with schizophrenia and have been associated with some Atypical antipsychotic medications. Periodic assessment of these conditions by the treating team is important, as is ensuring that consumers have access to primary health care (e.g. General Practitioner, Dietitian, Dentist etc) to provide appropriate care as necessary.

- **Housing and Homelessness**

The level of a consumer's independence is often indicated by the level of accommodation support required. Some consumers are unable to live independently or with their family and need supported accommodation. The type of supported housing available to people with mental disorders is dependent on the local availability of resources (McCrone & Strathdee, 1994). Homelessness can occur and the clinical care of homeless mentally ill consumers involves a process of intensive and assertive outreach, and ongoing rehabilitation (McQuistion, Finnerty et al., 2003)

- **Cultural Factors**

Cultural factors are known to affect the course, diagnosis, and treatment of schizophrenia (Karno & Jenkins, 1993). Clinicians should be mindful of the extent to which cultural factors influence their diagnostic approach. In particular, it is essential to understand and respect the specific approach deemed to be most beneficial when assessing or treating a consumer with a Koori background (Sheldon, 2001; Vicary & Westerman, 2004).

- **Social Circumstances**

As the social circumstances of the consumer can have strong effects on adherence and response to treatment. Relationships with significant others (including children), family involvement, sources and amount of income, and legal status, are all areas that may be explored and included in treatment goals.

- **Substance Use**

Many consumers with schizophrenia have comorbid substance use disorders. The goals of treatment for consumer with schizophrenia with comorbid substance abuse are the inclusion of specific treatment strategies such as motivational interviewing which have been developed to assist with harm minimisation, abstinence, relapse prevention, and rehabilitation.

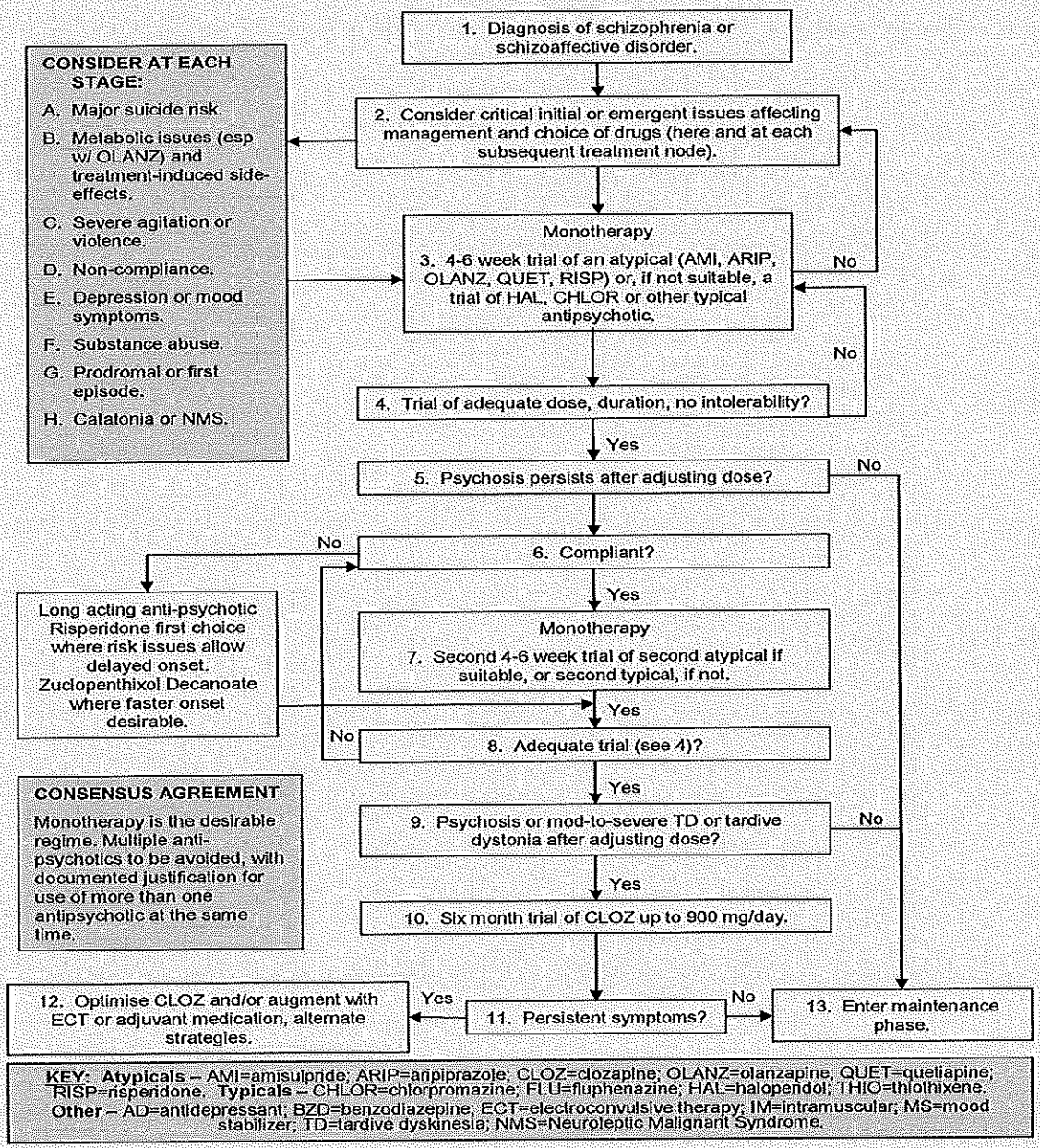
- **Legal Status**

The presence of involuntary status or CTO under the mental health act may have implications on a client's ability or willingness to engage in psychosocial interventions and is a factor that should be considered.

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

Schizophrenia Algorithm



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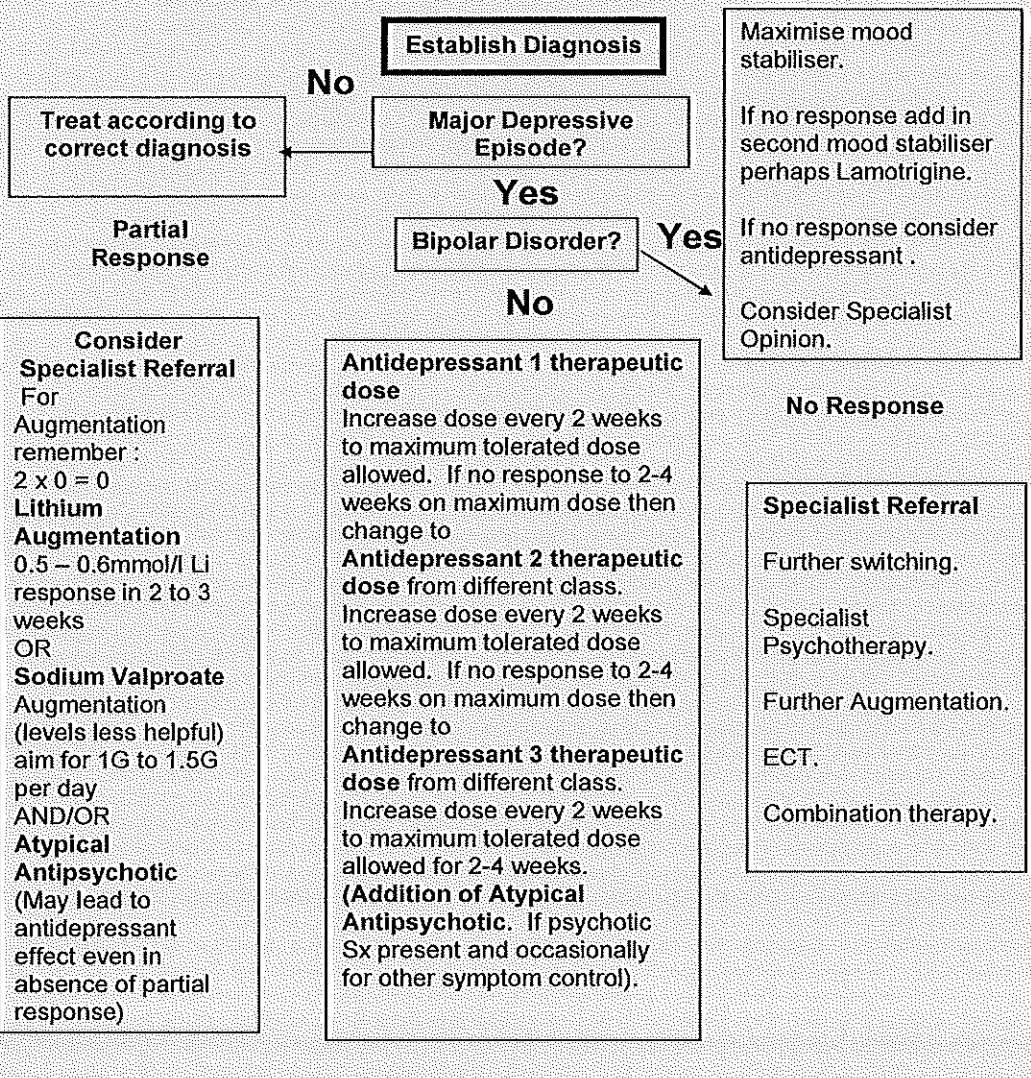
PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

Primary Care Treatment Algorithm for Depression
Peninsula mental Health Service

Consider at all stages

Diagnosis
Compliance
Substance abuse
Major Personality Problems
Physical problems presenting with depression or preventing response
Major social and relationship stressors
Alternative or addition of Psychotherapy



PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

SPECIFIC PSYCHOSOCIAL FOR SERIOUS MENTAL ILLNESSES (e.g. first episode Psychosis, Schizophrenia, Bipolar Disorder etc)

A number of psychosocial treatments have demonstrated effectiveness and include adherence therapy for medication compliance, Motivational Interviewing for comorbid Substance Abuse, family and individual psychoeducation, family interventions, cognitive behaviour-therapy, improving functional status and quality of life, supported employment, IPSRT for Bipolar Disorder, and social skills training.

- **Adherence therapy for Medication Compliance**

A crucial component of treatment and relapse prevention for consumers with schizophrenia or other mental disorders is adherence to medication. Research studies suggest that many individuals with schizophrenia are mostly very erratic with medication compliance and often only take partial amounts (Cramer & Rosenheck, 1994).

Compliance therapy is a focused CBT intervention aimed at improving compliance with medication. It proceeds over 4-6 sessions, utilising CBT, motivational interviewing and education elements. Sessions may include: eliciting attitudes to medication, linking of medication cessation with relapse, discussing misgivings about medication, weighing up benefits and drawbacks of treatment, framing of medication as a freely chosen strategy to enhance Quality of Life. In a randomised control study, Kemp et al (1998) found that there was an advantages compliance therapy over counselling at 18mth follow-up on insight, compliance, and community tenure. Despite the preliminary outcomes and the need for further research, practice guidelines recommend the use of compliance therapy as a way of increasing medication adherence.

- **Motivational Interviewing for Comorbid Substance Abuse**

Many consumers with schizophrenia have comorbid substance use disorders. The goals of treatment are harm minimisation, abstinence, relapse prevention, and rehabilitation. The most widely researched and efficacious intervention for substance-abuse is Motivational Interviewing. Motivational Interviewing is defined as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25).

Meta-analyses conducted on Motivational interviewing of 11 RCTs concluded that MI is efficacious with a variety of problematic substance-use behaviours (alcohol, marijuana, and opiate use) (Noonan & Moyers, 1997). A review on 29 RCTs (Dunn et al., 2001) found the greatest efficacy for MI when it was used to enhance more intensive substance-abuse treatments. The authors concluded that the optimal level of MI training, skills, and duration of treatment were still unknown. A recent meta-analysis on 22 relevant studies supported the hypothesis that MI is effective, in particular with younger adults who voluntarily seek help (Vailaki, Hosier, & Cox, 2006).

- **Family and Individual Psychoeducation**

The importance of providing psychoeducation for individuals with Schizophrenia and their relatives has been increasingly emphasized in recent years. The term psychoeducation was first employed by Anderson et al and was a behavioural therapeutic concept of 4 elements: briefing the consumer about the illness, problem solving training, communication training and self assertiveness(the training involved the relatives (Anderson (1980)A Cochrane review based on ten RCTs covering 1125 participants concluded that psychoeducation for schizophrenia significantly reduced relapse or readmission rates at 9-18 month follow-up, compared to standard care, with a number needed to treat (NNT) of 9. All but one study were group programs including family members. However, this result was from pooled data and as such does not reflect the often widely varying educational content, measures, and differing lengths of follow-up in most studies (Pekkala &Merinder, 2002).Reviews of controlled research on short term psycho education indicate improvements in knowledge and family burden but limited impact on the severity or course of psychiatric disorder. (Baucom, Shoham, Mueler, Diato and Tickle (1998) < Pitchel-Waltz, Leucht, Bauml, Kissling and Engel (2001). Numerous randomised trails on the other hand have shown longer term family intervention programs (more than 6 months) for schizophrenia have significant effect on reducing rates of relapse and rehospitalisation over 2 or more years. (Dixon et al 2001, Ptichel and Walz et al (2001) In addition, it was difficult to identify the most effective element of the studies, i.e. was it the family involvement or the educational component or non-specific factors such as professional support? Despite the inconsistencies, it is generally acknowledged that increasing consumers' and carers' knowledge and understanding of the illness and treatment may enable them to cope more effectively. In practice, psychoeducation may bring about less therapeutic benefit when delivered alone and tends to result in the best outcome when combined with family interventions and other psychological treatments (Roth and Fonagy, 2005; Turkington, 2004).

- **Family Interventions**

Family work for schizophrenia has a body of practice knowledge from research and from a developing area of clinical guidelines and Mental Health Government Directives. It is well recognized that relapse of schizophrenia within nine months to one year post discharge from hospital, is more likely to occur in consumers returning to stressful home environments and who experience major life events (Rea, 2003). Family interventions in psychosis research has a long history and show that better outcomes are achieved for people with schizophrenia by involving and working with family/ carers in educational and supportive way.

Since 1980 there has been 22 controlled studies of long term psycho-educational family work integrated with optimal drug and case management that has shown significant benefits for people with schizophrenia. These include 14 random controlled comparisons documenting significant clinical, social and economic advantage. Exacerbation of psychotic symptoms and admissions to hospital are more than halved, social disability is reduced and increase rates of employment, decrease rate of burden on family and carers and family/ carer improved health. For reviews of randomized trials

of family interventions when a family member experiences psychosis/schizophrenia see Bustillo et.al., 2001; Dixon et al., 2000, Mari and Streiner, 1996; Pharoah et al., 2002: Pitschelwalz et al., 2001). The outcome of Meta –analyses conclude that the evidence supports the provision of family-interventions in psychotic disorders (Pilling et al 2002)

Family focused therapy (FFT) aims to improve family function through a range of communication, problem solving training, illness education and relapse prevention. The results of a study by Johnson et al (2000), provides supports this and discusses how psychosocial interventions assist the consumer to cope with environmental triggers and compliance with medication. They also minimize stress to the family and improve family functioning through providing psycho-education, problem solving, coping training and relapse rehearsal. Minimizing relapse by assisting the family to develop ways to deal with the illness and manage the symptoms is the ultimate goal of FFT (Machado-Vieira, 2004).

Cochrane's (2006) review on family intervention for schizophrenia looked at the research data on the effects of family psychosocial interventions (FPI) in community settings. They selected randomized or quasi-experimental studies, focused on families of people with schizophrenia or schizoaffective disorder and compared standard care to community-orientated family-based psychosocial interventions that were greater than 5 sessions. The review showed that family intervention may decrease relapse rates, encourage compliance with medication and improve general social functioning.
The review, however, found deficits in the lack of blinded studies. There were no Category A studies and only one met Category B.

There is also a body of evidence supporting the heavy burden of care placed on family and other informal Carers of the seriously mentally ill (Fadden, Bebbington and Kuipers, 1987 Carey and Leggatt, 1987) created by lack of information on all aspects of illness, as well as inadequate training in the techniques of management and care. Research findings show that better outcomes are achieved for people with mental illness by involving and working with their families. Providing psycho-education for families has been covered in previous section. Research has shown a significant reduction in relapse rate of consumers who were treated with psycho-educational approaches. Three major studies include Falloon et.al., (1985) In a nine month period following discharge the relapse rates were dramatically lowered for patients involved in family treatment (6 % relapsed) compared to those on individual treatment (44% relapse). Hogarty and Anderson et al (1986) also showed decreased relapse rates. McFarlene et al (1990) combined psycho-education with multiple family groups. Of three treatments randomly assigned, the psycho-educational multiple family group approach resulted in the lowest relapse rates at one year (12.5) for patients diagnosed with schizophrenia.

This evidence base along with clear policy directives and the acceptability of family interventions to those who need them directs the inclusion of family interventions as a core component of psychosocial interventions.

Directives to improve support and involvement with families and Carers include;

- Working together with families and carers (April 2005) Clinical Practice Guidelines.
- 3rd National Mental Health Plan (2003-2008),
- The New Directions for Mental Health Services, The Next Five Years (2002)
- Caring Together: An action plan for carer involvement in Victorian public mental health services (2004) are policies which all support the improvement to support for families and carers.
- Chief Psychiatrist Guidelines, Working Together with Families (2005)
- Australian Government Department of health and aging "Principles and actions for Services and people working with Children of Parents with a Mental Illness (2004)

- **Cognitive-Behaviour Therapy for Psychosis (CBT)**

Therapy (CBT) has a long history of well documented research efficacy and clinical effectiveness for depression and anxiety disorders (Roth & Fonagy, 2005). More recently, studies have shown that positive symptoms of Schizophrenia, previously thought to be solely biologically-based, are amenable to psychological interventions (Kuipers, Garety, Fowler & Freeman et al., 2006). CBT for psychosis is an adaptation of cognitive behavioural interventions for depression and anxiety, with a specific focus on the reduction of positive symptoms such as hallucinations and delusions and the associated distress, through belief modification, reattribution, normalising of the illness, and increasing coping strategies (Durham, 2003; Kuipers et al., 2006; Turkington, Kingdon, & Weiden, 2006). There is also some evidence that negative symptoms of schizophrenia can also be reduced by CBT. According to Turkington et al (2004), co-morbidities of schizophrenia such as anxiety, depression, obsessive compulsive disorder and phobic symptoms may also be assisted with CBT.

Overall, meta-analyses of Random Controlled Trials (RCTs) of CBT specifically applied to psychotic symptoms show best evidence for improvements in persistent positive symptoms (Kuipers, Garety, Fowler, Freeman, Dunn, & Bebbington 2006). Medium to large initial treatment effect sizes have been found for some studies (Drury, Birchwood, Cochrane, & Macmillan, 1996; Kuipers, Garety, Fowler, Dunn, Bebbington, Freeman, & Hadley, 1997; Tarrier, Beckett, Harwood, Baker, Yusupoff, & Ugarteburu, 1993), but often benefits have not been found to be durable over longer periods. Conversely, Sensky et al. (2000) found no initial benefit over a 'befriending' group, but improvements were maintained over time for those in the CBT group. Further, studies focused on chronic patients have found that while CBT does not necessarily reduce the likelihood of relapse, it does appear to reduce the cycle of relapse and provides benefits in improved mental state (particularly for delusions) and functioning. On the other hand, the benefits to those in the more acute phase of the illness are less clear (Roth & Fonagy, 2005).

Further studies that focus on questions of specificity and durability are still required to inform the development of CBT for psychosis (Birchwood & Trower, 2006; Jones, da Mota Neto, & Campbell, 2004; Tarrier & Wykes, 2004; Turkington, Kingdon, and Weiden, 2006). Despite the inconsistencies, the results of research has been sufficient to support the relative efficacy of CBT as an adjunct treatment in reducing symptoms and distress for individuals who suffer from schizophrenia (see Pfammatter, Junghan & Brenner, 2006 for review).

- **Improving functional status and quality of life**

Mental illness can impact on every aspect of daily life, creating changes in functional ability and quality of life. Symptomatic improvement through effective medication and compliance may not necessarily be closely related to functional change, these domains can exist relatively independently. (Harding et al 1997; Mueser & Bellack, 1998). The psychotic disorders report summary concludes that "meeting adequately their multiple needs-related to treatment, housing, rehabilitation and daily living support is much more likely to have a greater impact on the course of their disorders and social adjustment than the provision of anti-psychotic medication alone (Jablensky, McGrath et al., 1999).

A primary treatment goal is to enable the client to continue the recovery process. To achieve the goal of improved functioning and quality of life, psychosocial and rehabilitative interventions are essential. Assessment of function aims to address client's strengths, difficulties, supports, and resources. This defines scope for interventions in specific life domains (ADL's, social skills training and social network enhancement, and occupational, recreational and vocational functioning) and facilitates the selection of intervention strategies to build on these strengths and resources and accommodate ongoing disabilities (Clare & Birchwood 1998; Rapp 1993). These life domains are outlined below. Interventions can be best provided in individually or through the use of groups and activities.

Functional rehabilitation involves the acquisition of skills in activities of daily living (ADL) (e.g. personal care, meal preparation, nutrition, budgeting, shopping and use of public transport). The onset and course of mental illness can disrupt the development of these skills (Meadows and Singh 2001).

- **Occupational, Recreational and Vocational Rehabilitation**

Occupational, recreational and vocational rehabilitation can be provided in a variety of ways. (i.e. skills training, provisions of direct opportunities for participation of various kinds of daily living social, leisure and vocational occupations, or reintegration into these occupations within the community (Meadows and Singh, 2001). The "healing potential" (Meadows and Singh, 2001) of work for with people with mental illness is widely recognised (Keilhofner, 1997; Peloquin, 1989; Sheppard, 1988). Supported employment (individual placement and support) involves direct, individualised approach to obtain and sustain appropriate work via ongoing professional support and modification of the workplace environment (Bond

et al, 1998). Randomized trials have consistently demonstrated the effectiveness of supported employment in helping persons with schizophrenia to achieve competitive employment (Bond, Drake, Mueser et al., 1997; Bond, Becker, Drake et al., 2001).

- **Social skills training**

Social skills training and Social Network enhancement is an essential component of psychosocial rehabilitation (Corrigan et al, 1992) and is used widely in the rehabilitation of community social functioning and social adjustment of people with schizophrenia (Halford and Hayes, 1991; Mueser et al, 1995). It is an integral component of all aspects of functional rehabilitation (Meadows and Singh, 2001).

The results of controlled trials indicate the benefit of skills training in improving illness knowledge, social skills, and symptom and medication management when offered with adequate pharmacotherapy (Heinssen, Liberman, & Kopelowicz, 2000). Evidence is strongest for the benefit of skills training in increasing the acquisition of skills assessed by situationally specific measures.

Clinical trials have supported the efficacy of social skills training (Eckman, Wirshing, Marder, et al, 1992; Hogarty, Anderson, Reiss, et al, 1991; Marder, Wirshing, Mintz et al, 1996; Wallace, Liberman, MacKain, et al, 1992)

Social Skills training can be conducted individually but is generally conducted in a group setting and there is some evidence from four studies to date, that supplementing supported employment with skills training resulted in improved tenure after getting jobs and increased job satisfaction (Kopelowicz, Liberman, & Zarate, 2006).

- **Interpersonal Therapy Social Rhythm Therapy (IPSRT) for Bipolar Disorder (Hamden et al., manuscript)**

IPSRT is a modification of interpersonal therapy developed by Kleman, Weissman, Rounsaville and Chevron (1984), supported by Goodwin and Jamison (1990).Their "i01nstability" model of bipolar illness, and is derived from the social zeitgebers model of mood disorders where it is believed environmental and social influences play a significant role in illness stability. It has been suggested that situations which disrupt circadian functions as well as psychosocial stressors, are both associated with increased risk of relapse. (Jones, 2001)

Goodwin's model focuses on stressful life events, disruption in social rhythms and non-compliance with medication believing them to be the key in destabilization for clients already maintained on medication. It is a model that has grown from IPT where mood and life events were the focus, to include the occurrence of events that are disruptive to the client's daily routine. The object is for clients to learn control over their life events, by monitoring and charting their routines, goal setting, cognitive restructuring and graded behavioral tasks, to achieve a balanced lifestyle and consequent reduction in episodes of mania and depression.

PENINSULA HEALTH COMMUNITY MENTAL HEALTH SERVICE

MODEL OF CARE

Frank et al, 1999 conducted a randomized controlled trial of 175 acutely unwell clients with a diagnosis of bipolar disorder 1 or schizo-affective disorder, manic type, using one of 4 treatment pathways which consisted of :acute and maintenance IPSRT, acute and maintenance intensive case management (ICM), acute IPSRT followed by maintenance ICM and acute ICM followed by ISPRT. There was a 2 year period of preventative maintenance. Participants were required to be in an acute phase of their illness and recruited through referrals and were seen weekly until stabilized. 2nd weekly sessions were held for 12 weeks followed by monthly until the end of the 2 year period. The IPSRT group's sessions focused on quality of social relationships and social roles, balancing and regulating daily routines, connections between mood symptoms and recognition of participants who may be a risk of rhythm interruptions. Resolution of interpersonal problems such as unresolved grief and role transitions was also part of the session and they ranged from time periods of 45-55 minutes.
The ICM group was a medical approach to treatment focusing on educating participants about bipolar illness, medication management, sleep hygiene and symptom recognition, review of symptoms and side effects, medical and behavioral management of side effects and non-specific support. Sessions were of 20-25 minutes duration. Findings favored the IPRST group in the acute phase with longer periods of time to relapse and the higher likelihood to stay well for 2 full years attributed to more regularity of social routines and had better outcomes for physically well participants.

SPECIFIC PSYCHOLOGICAL INPUT TO PHMHS
(Informed by Standard 11.4.D of National Standards for Mental Health Services)

- **Neuropsychology**

Requests for Neuropsychological assessments are formally requested and approved by the consultants on the relevant team using the Neuropsychology referral form.
All requests go via the Neuropsychology referral form to the neurophysiologist employed by the service.

- **Clinical Psychology**

Use of clinical psychologists for investigative purposes is sometimes required. On such occasions, the consultant psychiatrist on a given team may request specialist input into clients who are proving to be a diagnostic or treatment dilemma. Psychologists may be requested to do additional assessments such as Minnesota Multiphasic Personality Inventory (MMPI), SCID II etc and provide interpretation of these measures to the referring team.

On occasions, the Early Psychosis Service clinicians (with consultant approval) may request further assessment of a client in order to assist with the development of an integrated formulation, and thus aid diagnosis or treatment options.

- **Psychological Treatment**

Psychological strategies that include the Core Care Workbooks are provided by all clinicians working at Peninsula Health Mental Health Service to assist individual clients

to manage distressing symptoms of their illness, increase their self-esteem, and assist with recovery.

However, at times clients may experience ongoing symptoms of depression, anxiety, self-esteem or psychosis that may be significantly interfering with their recovery and the need for specific and more focused psychological therapies may be indicated. In addition, group programs are run to assist numbers of clients to manage these symptoms.

Specific psychological therapies offered or recommended by PHMHS for individuals are based on the best available evidence and are conducted by appropriately qualified and experienced clinicians. In general, PHMHS attempts to refer out to other agencies whenever possible and the extent to which clinicians at PHMHS directly provide these therapies is defined by the assessed needs of the clients and the availability of the appropriate services in the community.

Psychologists and Cognitive-Behaviour Therapists in the service are able to provide time-limited and evidence-based therapy. In addition, a university accredited "Introduction to Cognitive-Behavioural Therapy" course is offered to clinicians across the service, which increases the ability those from all disciplines to treat discrete problems with specific psychological strategies.
All these treatments are internationally accepted evidence-based practice based on Random Controlled Trials and current practice guidelines. For example:

- **Generalised anxiety:** Pyschoeducation re the worry cycle; Slow breathing for relaxation; thought stopping; relaxation training; worry time; cognitive errors in anxiety; challenging the "what ifs?" etc.
- **Panic disorder:** Psychoeducation re the panic cycle; Controlled breathing; cognitive challenging for catastrophic misinterpretation of bodily sensations; avoiding avoidance etc.
- **Depression:** Psycho-education re CBT model of depression; Activity Scheduling; graded task assignment, challenging unhelpful thoughts, problem solving, assertiveness etc
- **Bipolar Disorder**: Cognitive-Behavioural Therapy/Interpersonal & Social Rhythms Therapy
- **Psychosis:** Psychoeducation re psychosis including reformulating the story; coping with auditory hallucinations using a coping tool; gently challenging of loosely-held delusional beliefs to increase insight.
- **Low self-esteem:** Assertiveness training; problem solving; challenging contingent assumptions etc
- **Substance Abuse:** Motivational Interviewing

Ongoing mentoring/supervision for clinicians who have undertaken the training is provided by the psychologists or suitably qualified clinicians in the service.

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At times, more specific and focused psychological therapies are provided by clinical psychologists in the service when the relevant team recommends additional psychological treatment (unable to be accessed elsewhere) for persisting symptoms or specific comorbid disorders that significantly interfering with recovery.

For example:

- **First Episode Psychosis** *Cognitively Oriented Psychotherapy for First Episode Psychosis* (COPE) or CBT for psychosis,
- **Persisting hallucinations or delusions**: Cognitive-Behaviour Therapy, Compliance Therapy
- **Bipolar Disorder**: Cognitive-Behavioural Therapy/Interpersonal & Social Rhythms Therapy
- **Severe Agoraphobia**: Exposure Therapy
- **Simple/Social Phobia**: Exposure Therapy, Cognitive Therapy
- **Obsessive-Compulsive disorder**: Exposure and Response Prevention
- **Posttraumatic stress disorder**: Exposure Therapy
- **Eating Disorders**: Cognitive-Behaviour Therapy

Referral of Clients to Appropriately Trained Clinicians or Psychologists
A comprehensive assessment of an individual is conducted on initial intake to the service and presented to the relevant team. If the need for specific individual psychological interventions is recommended at the point of entry, ***the client is allocated following a discussion and agreement with the team.***

If a client is currently being managed by another clinician, referrals for specific psychological therapy can be made by any clinical staff member following discussion and agreement with the team manager and consultant by using the Transfer/Discharge Form with the following information:

- Name and age of client
- Diagnosis
- Diagnosis or symptoms for which the specific assessment or treatment is requested
- Previous treatment attempts including reasons the client cannot be referred elsewhere
- Specific treatment request

Clients will be allocated according to the perceived need of the client to either:
a) A clinician who has had training in CBT and is under supervision or
b) A psychologist or CBT therapist either on the team or on another team. Allocation to a clinician will occur within two weeks and is based on the current case load level of available clinicians and psychologists. At times there may be a waiting period.

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MODEL OF CARE

Structure for Individual Psychological Therapy

- **Phase One of Treatment**

Upon allocation, the treating psychologist or trained clinician conducts any further assessment required and writes a case formulation with recommendations for either proceeding onto a structured psychological therapy, and/or recommendations for different referral options that the team may consider.

Clients are to be informed of the potential benefits and commitment to treatment in order to assist them in making an informed choice when a particular psychological intervention is recommended to them.

If structured treatment proceeds, the psychologist or trained clinician collaboratively develops goals for treatment with the client and estimates the number of sessions required and informs the treating team. The time frame is generally between 8-10 sessions but may at times be up to 20 sessions for more complex cases (negotiated within the relevant team and based on the psychologist's or trained clinician's recommendations and available resources).

- **Phase Two of Treatment**

Structured psychological treatment is conducted at the mental health service and specific techniques and outcomes are well documented. In addition to the required measurements such as HONOS and BPRS, well validated and reliable assessment measures such as the Beck Depression Inventory (BDI-II) or Montgomery & Asberg Depression Rating Scale (MADRS) are utilised for depressive symptoms and the Beck Anxiety Inventory (BAI) for anxiety symptoms. These are given at baseline and repeated at intervals during and at the end of treatment in order to monitor the ongoing effectiveness of the psychological therapy being conducted and to ensure quality of service.

- **Review and Discharge**

A review of psychological treatment outcomes is to be presented to the relevant team at three monthly reviews, the point of discharge from the service, or at transfer back to case management.

PSYCHOLOGICAL INPUT TO PSYCHIATRY IN OTHER PARTS OF THE SERVICE

- **Psychological Input on 2West**

A psychologist is allocated to the inpatient unit (2West) for one session per week. The psychologist runs a patient group supported by unit staff, as part of the Structured Activities Program. The group is called Stress Management and is run once a week for one hour and covers topics such as 'anxiety management', 'problem solving', activity scheduling', 'assertiveness training' etc.

In addition, the psychologist may be available to deliver individual psychological assessment and treatment and provide input to management plans on the unit on an as needed basis and as time permits. Any requests for psychological treatment or input must be requested by the unit consultants to the psychologist allocated for the unit.

In addition, the psychologists of the service provide training for staff on the inpatient unit in brief interventions that may be implemented effectively on the unit.

- **Psychological Input to CCU**

A psychologist is allocated to the Community Care Units for one session a week. Clinicians at CCU are able to request short-term CBT for clients who are suffering from a specific disorder, which is impacting on their quality of life but for which there is no-one able at the CCU with sufficient expertise to provide the treatment.

In addition, training in basic psychological strategies is provided to assist clinicians in both up-skilling themselves in providing evidence-based strategies to assist their residents and to enable them to make appropriate referrals for disorder specific CBT treatment from psychologists in the service.

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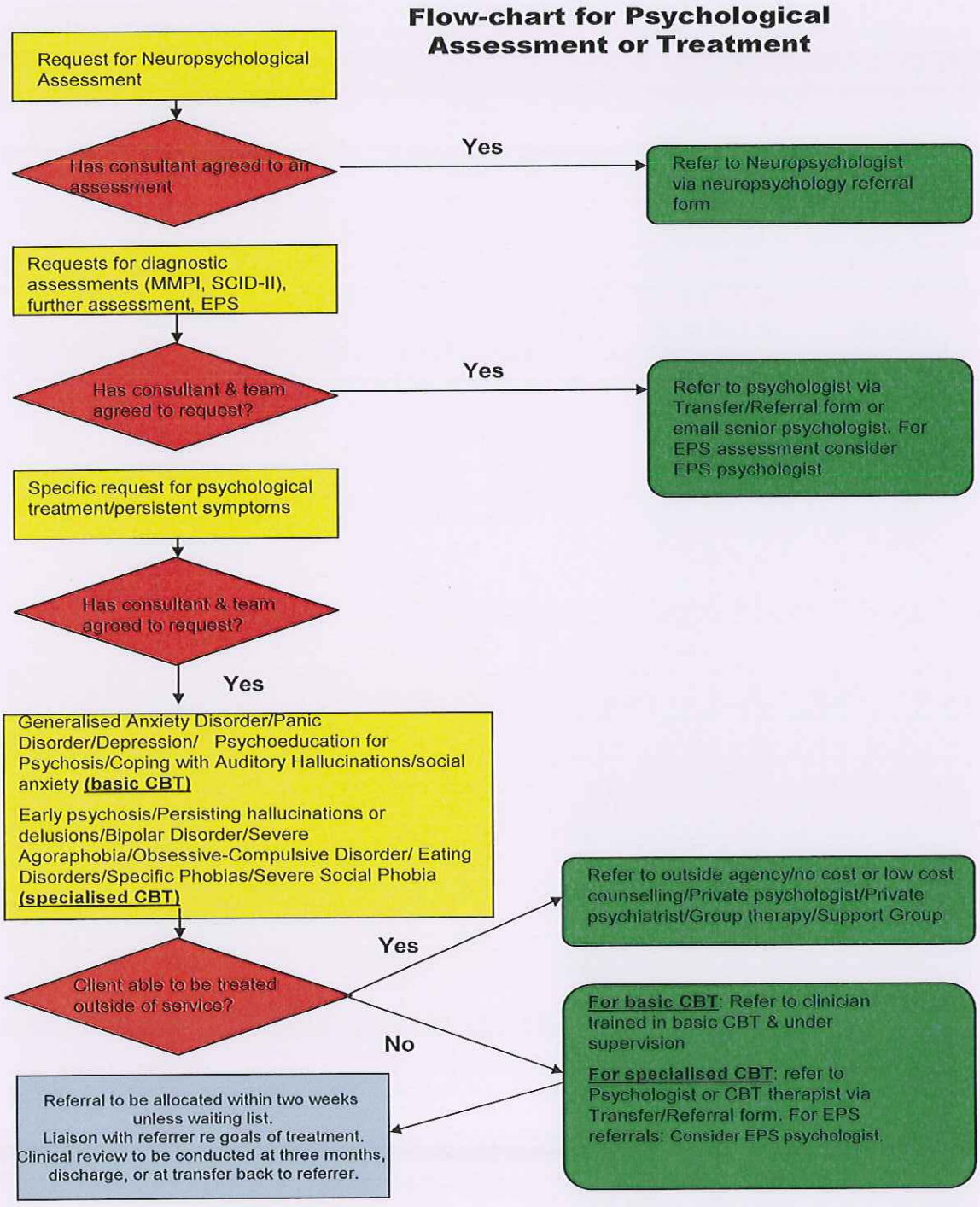

Facilitating Stronger Partnerships with PDRS.

Some consumers may require intensive psychiatric rehabilitation as part of recovering from a psychiatric illness. Referral to a PDRS for psychosocial support can be a powerful way of promoting recovery. The underpinning principles of a PDRS are articulated in "An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability: Project Report" and Victoria's Mental Health Services Psychiatric Disability Rehabilitation and Support Services: Guidelines for Service Delivery 2003.

….. "the provision of ongoing support that assists the person with a psychiatric disability to experience an improved quality of life, learn or relearn the skills of daily living, participate to the maximum extent in social, recreational, educational and vocational activities and live successfully at an optimal level of independent functioning in the community. The role of rehabilitation is skill development, developing peer support, exploration of self and illness through creative pursuits."

The Alliance project was established as a way of enhancing the collaboration between the mental health service and the PDRS. It was recommended that the clinical and PDRS alliance initiative include the following among the expected outcomes:

- Common tools of assessment, planning and management of consumers for maximum rehabilitation and recovery outcomes
- That both organisations work collaboratively to identify and target complex consumers
- To consider the potential for each service to increase or decrease intensity of service for consumers if their level of functioning changes as opposed to engaging another service
- To develop a culture of shared ownership (responsibility) of the population of people

7. EVALUATION

- Monthly Clinical File Audit
- Clinical Case review for each client receiving service
- Client, carer and clinician survey

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9. CLINICAL PRACTICE GUIDELINE HISTORY

- Created September 2008
- Revised August 2010

10. KEY PERFORMANCE INDICATORS/ OUTCOME

- Routinely collect outcome measures: Honos /Basis 32
- Hospital admissions and re-admissions
- Community re-admissions within 6 months
- Admissions/Re-admissions
- Ratio between voluntary and involuntary patients
- Consumer surveys
- Carer surveys
- Clinician surveys
- Employment rates (ready to work)
- Substance abuse status

ENCLOSURE C

CLINICAL PRACTICE GUIDELINE

Peninsula Health

MENTAL HEALTH SERVICE

COMMUNITY e-BOARDS

1. INTRODUCTION

The Community Liaison Early Intervention Acute and Recovery Service (CLEARS), Aged Persons Mental Health Team (APMHT) and Mental Health HARP (MH HARP)e-boards evolved as part of the revised model of care for Peninsula Health Community Mental Health Service (PHCMHS). This is used as a visual monitoring aid, alerting mental health staff of clients currently receiving service, from the CLEARS, APMHT Intensive Community Treatment service (ICT) and MH HARP who are acutely unwell requiring increased service provision.

2. PURPOSE

The aim of this guideline is to ensure all PHCMHS teams are utilising the e-board in the manner it is intended, uniformly across the service.

3. DEFINITIONS

- **CLEARS** is the integrated adult community mental health service operating across the catchment area.
- MH HARP is the service engaging clients who present frequently to Peninsula Health Emergency Departments (ED). It is not an acute service, however clients of MH HARP are likely to at times experience crises and require acute follow up, or assessment in the ED.
- **The ICT** is the acute component of the APMHT; however do not provide an acute assessment function.
- **The e-board** – is the electronic recording document of clients who require more intensive input in relation to acute mental health issues. The e-board will list the following: date of referral, first name and surname of client, suburb PH UR number, age, , diagnosis, PH Clinician, health professional, Mental Health Act status, issues and short term plan, level of risk, date of medical review, specific daily intervention i.e. am, pm, evening, discharge date and discharge destination
- **PH Clinician** – Recovery Clinician, initial assessor or as agreed within the team.

4. RELATED POLICIES/ CLINICAL PRACTICE GUIDELINES

- Peninsula Health Community Mental Health Model of Care
- 5.1.01 OH&S risk management
- 5.1.22 Home / community visiting – staff safety policy
- 3.1.27 Risk Management policy
- Mental Health CPG Home Visiting Risk Assessment Tool

5. RESPONSIBILITIES

5.1. **Employer** – The employer shall be responsible for ensuring the e-board is used in accordance with the community model of care details the responsibilities for ensuring that the Clinical Practice Guideline is adhered to.

5.2. **Departmental** – The e-board is available on the M drive where it is accessible to be viewed by other staff within the service including senior managers and those with clinical responsibilities. The e-board will be password protected and may only be edited by the team.

5.3. **Department Head/Manager/Shift Leader** – Team Managers, their deputy and Shift Leaders have a responsibility to ensure that the information on the e-board is factual and up to date.

5.4. **Employee** – The e-board is the responsibility of the CLEARS team, APMHT/ ICT and MH HARP. Administration staff will use the e-board to identify which staff member is the responsible clinician. Any staff member with clinical responsibility for a client may use the e-board, to add their client, amend details as necessary, update progress at least daily, and remove their client **after discussion and agreement with the Consultant Psychiatrist**. Rostered staff will have responsibility for clients not allocated a Recovery Clinician, yet requiring intensive acute Mental Health Team input. This e-board is visible to all Peninsula Health employees and the language and grammar used should meet appropriate and expected professional standards. Employees are obligated to maintain client confidentiality including the appropriate disposal of hard copies of e-board sheets.

6. CLINICAL PRACTICE GUIDELINE

E-BOARD

The e-board is a tool set up to highlight clients within any team who require more intensive input by the team.

- The e-board lists demographic details, risk issues and a brief plan for the next scheduled contact.
- All staff members within the team will use the e-board.
- Clients with a recovery clinician may be escalated to the e-board should the level of acuity of their mental health issues increase requiring intensive input.
- Clients discharged from the in-patient units and referred for community follow up; are added to the e-board to ensure timely interventions post discharge.
- Clients referred by CLIPS triage and/or the Emergency Department will be placed on the e-board
- The names of all clients discharged/transferred from the inpatient units to the community teams are to be recorded on the e-board for each team until contact has been made with the client. This contact is to be made within 72 hours and is face to face unless otherwise agreed and documented.
- All clients listed on the e-board will be reviewed by the treating team daily.
- A copy of the e-board from the previous day will be saved on the M drive each day by the rostered clinician working the afternoon shift. This is achieved by the clinician creating a duplicate copy of the current day's e-board. (File, Save as, change the date to tomorrow's date and enter). Update the relevant information for the next day and save. Once this is completed move the e-board for the current day into the relevant months folder for archiving.
- All printed copies of the e-board are to be shredded to protect clients' privacy and confidentiality
- Client details will only be removed from the electronic e-boards following team Consultant Psychiatrist review of their acuity and current support needs.

ALERT BOARD

In addition to the e-board showing clients requiring acute intensive input, there is also a section listing clients on **'Alert'** only, which includes:

- New non urgent referrals.
- Current clients whose mental state has improved to such a degree that they no longer require intensive team input, however may have follow up medical review organised or where the team is awaiting confirmation client has attended to follow up appointments
- Missing clients
- Pending referrals
- One-off medical reviews

Clients can be moved from the ACUTE section of the e-board to the ALERT ONLY section, as part of the transition to discharge as per clinical review.

The alert only section of the eBoard will be considered daily and formally reviewed at a minimum weekly.

6.2 CLINICAL CONSIDERATIONS

Clients whose assessed mental state indicates an increased clinical risk, or those who require increased intervention should be discussed in community teams' morning meetings, where decisions regarding future team input, including management and treatment planning can be made. This may result in escalating the client to the e-board in order that more intensive clinical input is recognised or to plan increased clinical input. Where this decision is made outside the team meeting the individual clinician is responsible for entering the client on the e-board and discussing with the team at the next team meeting.

6.3 REQUIREMENTS

If a client has a recovery clinician, and their mental state warrants escalation to the e-board, it is the responsibility of that clinician to provide the increased intensive input, in conjunction where necessary with other team members, including the after hours staff.

7. EVALUATION

- Feedback to individual Team Leaders regarding problems / difficulties with the e-Board

8. REFERENCES

- NSMHS – Standard 10 – Delivery of Care
- Peninsula Health Community Mental Health Model of Care
- Policy 7.1.21 – Patient confidentiality

9. CLINICAL PRACTICE GUIDELINE HISTORY.

- No previous versions of this procedure.

10. KEY PERFORMANCE INDICATORS/ OUTCOME

- Audits as required.